1982

Client Commitment to the Helping Relationship

J. P. Lemkau

Fred B. Bryant
Loyola University Chicago, fbryant@luc.edu

P. Brickman

Strupp, H. H., & Bloxom, A. L. Preparing lower-class patients for group psychotherapy: Development and evaluation of a role-induction film. *Journal of Consulting and Clinical Psychology*, 1973, *41*, 373–384.
Suchman, E. A. Stages of illness and medical care. In E. G. Jaco (Ed.), *Patients, physicians and illness: A sourcebook in behavioral science and health* (2nd ed.). New York: Free Press, 1972.
Svarstad, B. L. Physician–patient communication and patient conformity with medical advice. In D. Mechanic (Ed.), *The growth of bureaucratic medicine: An inquiry into the dynamics of patient behavior and the organization of medical care*. New York: Wiley, 1976.
Szasz, T. S., & Hollender, M. H. A contribution to the philosophy of medicine: The basic models of the doctor–patient relationship. *Archives of Internal Medicine*, 1956, *97*, 585–592.
Tagliacozzo, D. L., & Mauksch, H. O. The patient's view of the patient's role. In E. G. Jaco (Ed.), *Patients, physicians and illness: A sourcebook in behavioral science and health* (2nd ed.). New York: Free Press, 1972.
Taylor, S. E. Hospital patient behavior: Reactance, helplessness, or control? *Journal of Social Issues*, 1979, *35*(1), 156–184.
Taylor, S. E., & Levin, S. *The psychological impact of breast cancer: Theory and research*. San Francisco: West Coast Cancer Foundation, 1976.
Thompson, S. C. Will it hurt less if I can control it? A complex answer to a simple question. *Psychological Bulletin*, 1981, *90*, 89–101.
Timiras, P. S. *Developmental physiology and aging*. New York: Macmillan, 1972.
Ursin, H., Baade, E., & Levine, S. *Psychobiology of stress*. New York: Academic Press, 1978.
Weiss, J. M. Effects of coping responses on stress. *Journal of Comparative and Physiological Psychology*, 1968, *65*, 251–260.
Weiss, J. M. Somatic effects of predictable and unpredictable shock. *Psychosomatic Medicine*, 1970, *32*, 397–408.
Weiss, J. M. Effects of coping behavior with and without a feedback signal on stress pathology in rats. *Journal of Comparative and Physiological Psychology*, 1971, *77*, 22–30.
Wortman, C. B., & Brehm, J. W. Responses to uncontrollable outcomes: An integration of reactance theory and the learned helplessness model. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 8). New York: Academic Press, 1975.
Ziemelis, A. Effects of client preference and expectancy upon the initial interview. *Journal of Counseling Psychology*, 1974, *21*, 23–30.

chapter 9

Client Commitment to the Helping Relationship

JEANNE PARR LEMKAU
FRED B. BRYANT
PHILIP BRICKMAN

Introduction

Prospective clients approach psychotherapy with ambivalence. Only when the pain, embarrassment, or incapacitation of their symptoms is great enough to overshadow their apprehensions do they turn to a professional helper. The anxiety inherent in self-disclosure, the discomfort engendered by the intimacy and dependency of the therapy situation, and the escalating cost of treatment naturally call for hesitation, and the client's anticipation of relief must be strong to counter these factors.

But will clients return for a second or third appointment after the initial visit? And if they do, will they "go through the motions" of therapy, or will attendance represent a deepening involvement in a therapeutic process? Will participation in psychotherapy eventually result in the beneficial relief of symptoms, or will clients simply be caught in an unproductive relationship, as sometimes evolves between helper and client (Bergin & Lambert, 1978)?

The construct of commitment, drawn from the literature in sociology (Becker, 1960) and social psychology (Festinger, 1957; Gerard, Connolley, & Wilhelmy, 1974; Brickman, Note 1) is eminently suited for considering such questions. Whether we consider the choice of persisting in therapy or

ISBN 0-12-757680-0

dropping out, actively investing oneself in a helping relationship or passively resisting help, we are dealing with the issue of commitment, or the development and maintenance of a consistent line of activity over time.

What do we mean when we say that a client is committed to a helping relationship? Inherent in such a statement is an appreciation for the time-binding capacity of humans—the anticipation of a better future motivating persistence in the current endeavor, in this case, perseverance in therapy according to the model of a particular helper. Commitment sets limits on the situational specifity of behavior (Brickman, Note 1). If not for the time-binding nature of commitment, each visit to the therapist and each interchange within the session would entail a new decision about whether to return or cooperate in treatment. Commitment also implies the experience of costs as well as rewards, thus distinguishing it from the complacent pursuit of a behavioral course involving no costs. In fact, persistence in therapy would be no issue were the enterprise a purely pleasurable one where symptom relief and personal growth were achieved without effort or anxiety. Commitment thus encompasses the choice and maintenance of a behavioral course about which one is initially ambivalent.

Elements of Commitment

In Brickman's conception (Note 1), commitment entails three elements: (*a*) positive aspects of an individual's experience, (*b*) negative aspects of that experience, and (*c*) a bond between these two that serves to impel the behavioral course. Commitment exists when people make a choice (an act that specifies a positive element) despite costs (a negative element) that they recognize and accept as entailed by that choice (establishing a bond between the positive and the negative elements).

The elements in this definition of commitment are drawn from several traditions. Becker (1960) represents the earliest effort within sociology to define the concept; according to Becker, commitments arise when, by making a "side bet," a person links extraneous interests with a consistent line of activity. With the accumulation of side bets, the consequences of inconsistency become so expensive that "inconsistency . . . is no longer a feasible alternative [p. 35]." If individuals remain in an aversive situation, despite opportunities to leave, it is because they have implicitly made something they value a good deal (e.g., their self-respect, or career advancement) contingent upon remaining in that situation. Thus, the aspiring analyst who has invested thousands of dollars in a personal analysis, the completion of which has become a condition for entering the fold of the psychoanalytic elite, is likely to be zealously committed to the final unraveling of his Oedipus complex. In this as in all cases, an understanding of this man's commitments entails "an analysis of the system of values or . . . valuables with which bets can be made in the world he [or she] lives in [Becker, 1960, p. 39]." For Becker, side bets and consistent activity are in principle distinguishable, thus avoiding the tautological use of the commitment construct.

The research on dissonance and self-perception calls attention to a complementary process by suggesting that people attach greater value to goals when they see themselves as incurring costs and making sacrifices in their pursuit. From the dissonance theory perspective, consistency between or among cognitions is viewed as pleasurable, whereas inconsistency is seen as dissonant and unpleasant, impelling the person to change cognitions and/or behavior in the direction of greater consonance (Gerard *et al.*, 1974). The man who has voluntarily invested in personal analysis would experience dissonance at the thought of the process being a useless one; dissonance theorists would emphasize the unique constellation of cognitions brought into relationship with each other in the context of the helping situation, and would understand his persistence in terms of dissonance reduction.

In another social-psychological analysis of commitment, Kiesler (1971) suggests that once people take responsibility for having chosen a behavioral course, they feel compelled to explain any change in behavior to others, or at least to themselves. Since people wish to avoid such explanations and the concomitant negative evaluations of self, their behavior becomes more resistant to change.

In this chapter, we apply the construct of commitment to achieve a better understanding of the pursuit of psychotherapy. In the following section, traditional descriptions of stages of psychotherapeutic involvement are presented and reframed as stages of commitment to the helping relationship. Subsequently, research on variables related to dropout from psychotherapy is discussed and related to commitment theory. Then we consider approaches to inducing and maintaining commitment, drawn from the literature in social psychology, and apply these to psychotherapy. Finally, we summarize and discuss briefly the clinical and research implications of a commitment perspective.

Traditional and Alternative Views of Perseverance in Therapy

From the psychoanalytic tradition springs the most detailed account of the course of the therapeutic relationship, unrivaled in regard to either the specification of stages in therapy or the theoretical import with which they are imbued. In their focus on the nature of the client–helper relationship as it changes over time, psychoanalysts have come remarkably close to a commitment analysis of therapy stages. Fine (1973) describes the main stages of psychoanalysis as those of "establishing a relationship, having an analytic

honeymoon, experiencing a first treatment crisis, deepening of therapy, working through (usually the longest period) and termination [p. 20]." Similarly, we see commitment to a helping relationship as initially involving strong positive attraction to the therapeutic endeavor, followed by several phases of ambivalence and resolution of the contradictory feelings aroused by the therapy situation. Our discussion will demonstrate the marked similarity between stages in psychoanalysis and stages of commitment to any behavioral course (Brickman, Note 1).

STAGES IN PSYCHOANALYSIS

In his eloquent treatise on modern psychoanalytic technique and practice, Greenson (1967) described characteristic phases of treatment, specifying the role of both helper and client in facilitating or impeding transitions through these phases. Greenson's discussion is replete with references to "polarities," "dialectic" processes, and paradoxical demands for the helper to alternatively foster "two opposing relationships between analyst and patient [p. 379]," one of indulgence and one of frustration, in order "to facilitate the growth of the transference neurosis as well as the working alliance . . . [which are] of equal importance for the development of the optimal analytic situation [p. 396]." Focusing on the client's contribution to the therapeutic dyad, Greenson argues that the client must bring to the helping relationship the experience of pain as well as the anticipation of pleasure. Since negative feelings about analytic treatment are inevitable, neurotic suffering on the part of the client is essential, since "only such a person will be willing *to try* to enter and work in the analytic situation [p. 360]."

The first stage in the analytic relationship involves establishing a working alliance between the patient and analyst that enables them to work purposefully together in the analytic situation (p. 192). The helper's nurturing of this working alliance takes the form of being relatively accessible, warm, and self-disclosing early in treatment and only retreating to a stance of greater distance and deprivation once a sufficient alliance has been formed, a psychoanalytic example of the "low-ball" approach to inducing commitment (Cialdini, Cacioppo, Bassett, & Miller, 1978). With a working alliance established, the patient attends therapy, cooperates in attemping to free associate and confront resistances, and conforms to other expectations of this model. In establishing this alliance the helper both implicitly and explicitly presents a psychoanalytic world view that encompasses both the the client's symptoms and anticipated relief, and the client either tentatively accepts this model or at least willingly suspends judgment.

Ideally, client resistances emerge as a major aspect of the therapeutic relationship only after a working alliance is established. The working alliance provides the helper with necessary leverage to confront the client's

resistances, that is, "all the forces within the patient which oppose the procedures and processes of psychoanalytic work [Greenson, 1967, p. 35]," or, in commitment terms, all the negative elements inherent in the therapy experience. The helper interprets the client's hesitation within the psychoanalytic framework as defensively functioning to shield the client from more painful levels of awareness, and carefully balances support and confrontation, lest "the deprivation and frustration of the analytic situation exceed the patient's ability to withstand such stress [p. 377]."

It is through the analysis of resistances that the "transference neurosis" emerges. For the client, a gamut of feelings from attraction to hostility toward the therapist emerge, as positive transference precedes and intermingles with negative transference. The helper interprets all expressions of feeling by the client toward the helper as distortion of reality based on the client's early relationships with parental figures. To the extent that the client accepts such a perspective, commitment to the *real* relationship between client and helper goes unquestioned and perseverance in therapy, to unravel to distortions of transference, is enhanced.

The heart of psychoanalysis is in the "working through" of the transference, a lengthy phase that involves the "repetitive, progressive, and elaborate exploration of the resistances which prevent an insight from leading to change [p. 42]." Continued contemplation of the nature of the psychoanalytic relationship is encouraged, but always as a means of understanding the client's problems. By working through the transference, the client translates insights about past relationships, as experienced in the therapeutic dyad, into new attitudes and behaviors. Within the psychoanalytic framework, as long as the helper is successful in fostering and maintaining the client's psychoanalytic world view, the client can only view leaving therapy before such working through as resistance, and perseverence in treatment becomes the only face-saving course.

Termination is the natural culmination of all of these stages and is considered premature if all stages have not been experienced. The client's desire to terminate, especially early in treatment, would generally be viewed as resistance since "intense and prolonged hateful reactions toward the analyst should emerge and be analyzed before one should think of terminating [p. 235]." Ideally, termination of treatment is contingent upon the helper's judgment that all neurotic material has been worked through, and on the client's total acceptance of the meaning of both positive and negative aspects of the therapy experience in psychoanalytic terms.

BRICKMAN'S STAGES OF COMMITMENT

Brickman (Note 1) proposed that the negative elements important to commitment change over time and that, as a consequence, commitments

characteristically pass through several stages. The first stage is an exploring or tentative one that parallels the establishment of a working alliance in Greenson's (1967) discussion of psychoanalysis. In Stage I commitment, no negative aspects of therapy are especially salient and the pain of symptoms and hope for relief are sufficiently intense to impel the client to become involved in a helping relationship. The surge of relief experienced early in treatment as a function of newfound social support enhances the positive aura of this phase.

The second commitment stage follows the initial honeymoon of commitment, as the emotional and financial costs of treatment become more salient with amelioration of the client's acute distress. This period is one of testing or challenging, in which the client faces obstacles to the pursuit of therapy and begins to question the value of further involvement. Whether the difficulties confronted involve financial sacrifices or painful emotions, the ambivalence of this phase can readily be seen as parallel to the experience of resistance in the psychoanalytic framework.

If the client is to persist in therapy beyond the ambivalence of Stage II, the positive rewards from therapy must be perceived as sufficiently large, important, and accessible to warrant the costs entailed in their pursuit. For example, a client may decide that the anxiety aroused by self-disclosing the details of her personal problems is "worth it" as she experiences the nonjudgmental response of the helper and accepts the helper's word that such anxiety is a necessary part of getting better. Thus, a resolution of ambivalence is the essence of Stage III commitment, which tends to be passionate and intense, reminiscent of positive transference in psychoanalysis.

Brickman postulates a subsequent stage, parallel to negative transference in psychoanalysis, in which the client recognizes problems with the enthusiasm of Stage III. Boredom is often characteristic of this phase, and disinterest may be a real threat to persistence. This is followed by a final stage in which a new resolution of the positive and negative elements experienced in the therapy relationship is achieved (Stage V), and a sense of completion and fulfillment predominates. Just as in the psychoanalytic example where positive and negative tranference intermingle and are worked through, here again we have a fluctuation between the recognition of negative and positive elements of the experience and the cognitive reorganization that fosters persistence in the face of ambivalence.

Eidelson's (1980) work on the development of dyadic relationships suggests that the positive and negative elements most critical for understanding the development of client commitment to the helping relationship may be conflicting motivations for affiliation and independence. He sees relationships as developing positively at first with the satisfaction of affiliative needs, followed by a period of decreasing satisfaction as the client experiences restricted independence. A subsequent phase of evaluation and internalization entails the resolution of positive and negative feelings. Within this

model, a client's commitment to the therapeutic relationship at a given point in time is seen as the result of the interaction of affiliative rewards and restrictive costs, and the individual client's sensitivities to these outcomes. For commitment to the relationship to continue in the face of the restrictive costs, the client must employ "a new frame of reference . . . which includes the particular relationship as a 'given' in the individual's social environment [Eidelson, 1980, p. 461]." One consequence of this new level of commitment is seen as a decrease in tension and ambivalence as the client reduces dissonance by deemphasizing the limitations and restrictions entailed by the relationship.

Eidelson's affiliation–independence model supplements the psychoanalytic example by providing another description of the interplay of positive and negative elements embodied within the commitment framework. Clearly, the phenomena psychoanalysts have described in terms of *working alliance*, *resistance*, *transference*, and *working through* may be acknowledged within the broader commitment context, without being accepted as proof of the validity of the psychoanalytic perspective. The commitment framework emphasizes the processes entailed in persistence in any behavioral course, without restricting the nature of positive and negative elements to those postulated within a particular theoretical domain.

COMMITMENT TO A WORLD VIEW

The role of the helper in fostering client commitment to psychotherapy is crucial. Specifically, to enhance persistence in treatment the helper must offer the client an interpretation of experience (or world view) that conceptually integrates the rewards and costs clients experience and anticipate within the helping relationship, and delineates the essential role of the helper–client dyad in achieving the client's goals. For example, the psychoanalyst may suggest to a client struggling with the tensions of the therapeutic situation that such obvious unresolved ambivalence toward parental figures can only be overcome via continued analysis with an expert who can recognize and interpret resistance. A Rogerian therapist, on the other hand, working within a belief system that emphasizes the role of the helper's unconditional positive regard for the client, may suggest to a client that self-acceptance and symptom relief can only be realized through self-disclosure within the context of a nonjudgmental therapeutic relationship.

We believe that for persistence in treatment the particular content of the world view is incidental, whereas what is critical is that a view is communicated whose content and manner of presentation are maximally acceptable to a particular client. Although a shared world view between helper and client has been emphasized as critical for psychotherapeutic gain (Frank, 1974; Torrey, 1972), here we emphasize its role in fostering perseverance in the therapeutic process.

Dropping Out of Treatment

To demonstrate the utility of our approach, we consider the literature on dropping out of treatment in terms of the commitment model. If Brickman's (Note 1) concept of commitment is fruitful in this regard then it should be possible to translate the variables identified as predictive of dropout into the terms of the model (as is, in fact, the case). The commitment concept provides a framework for integrating intrapsychic, relationship, and environmental factors usually discussed in relative isolation from each other. Furthermore, by encompassing both personal and situational factors, this framework may help therapists to avoid the "fundamental attributional error" (Ross, 1977) of overemphasizing personal factors and "blaming the victim" for an aborted therapy relationship.

Before pursuing the relationship between commitment processes and dropout, a caution is in order. In general, clients are considered dropouts if they fail to continue in therapy as long as the helper or researcher deems satisfactory, whereas from the clients' perspective one or two sessions may suffice. Several researchers have noted marked symptomatic relief in less than five sessions (Rosenthal & Frank, 1958; Uhlenhuth & Duncan, 1968) and even from a single session (Frank, 1963; Smith & Glass, 1977), findings consistent with the experiences of clinicians who treat clients under acute situational stress. Just one or two visits can also have a powerful impact on a client who imbues therapy seeking with special symbolic significance. For example, one of the authors (JPL) had a client suffering from a chronic "workaholic" lifestyle who attended only four sessions before dropping out. In a serendipitous social encounter several months later, the client reported that therapy had been extremely helpful because in the act of coming she realized that she could take time for herself. Although her helper saw her as a dropout, she was, in fact, a satisfied consumer, off on a European vacation that she thought was facilitated by her brief sojourn in therapy. Research on dropout could have a different flavor entirely were the perspective that of consumers rather than purveyors of therapy. Thus, in considering this literature one should be careful to avoid the assumption that dropout and therapeutic failure are synonymous.

Baekeland and Lundwall (1975) have critically reviewed the research on psychiatric patients dropping out of treatment from a variety of inpatient and outpatient facilities. Implicated in dropout were 15 variables falling into three general categories: (1) *characteristics of clients* (age, sex, socioeconomic status, social isolation, social instability, symptom level, motivation, psychological-mindedness, behavioral and/or perceptual dependence, and specific symptoms such as aggressiveness, sociopathy, and drug dependence), (2) *characteristics of helpers* (therapist attitudes and behaviors and discrepant treatment expectations of helper and client), and (3) *characteristics of the environmental context* of therapy (family pathology, attitudes, and behavior).

Some of the variables related to dropout directly contribute positive and/or negative elements to the therapeutic endeavor. Others contribute to perserverance or dropout by facilitating conceptual bonding of positive and negative elements in the therapy experience. Each of these will be discussed in turn, with references to the literature as reviewed and summarized by Baekeland and Lundwall.

CONTRIBUTION OF POSITIVE AND NEGATIVE ELEMENTS

Variables related to dropout contribute positive and negative elements to the cost–benefit analysis in which every client engages in the pursuit of psychotherapy. For example, some clients may be more sensitive than others to the positive elements of a warm, supportive relationship with a helper. More socially isolated individuals, prone to drop out, have difficulties forming relationships in the first place, they may therefore be either less enticed by the benefits of a therapy relationship or less able to handle a supportive relationships in the first place; they may therefore be either less enticed by the anxiety, who tend to persevere, may represent cases in which the positive benefits of a supportive therapy relationship are especially salient. Finally, aggressive, drug-dependent, and/or sociopathic clients may so disturb their helpers as to inhibit whatever investment of time, energy, and empathetic support they might otherwise provide, an example of how client and helper characteristics may jointly determine the "positives" available to the client from participation in therapy.

Since characteristics of helpers directly affect the quality of care offered to clients, it is hardly surprising that therapist ethnocentrism, boredom, and dislike of clients have been implicated in dropout, or that therapists who give poor instructions, cancel appointments, or do not support judicious use of medicine as an adjunct to therapy fail to hold clients.

The environmental context in which therapy takes place also contributes to clients' decisions about disengaging from therapy. When a person has a strong commitment to a pathological family system, the threat of its disruption or the opposition of important family members impedes compliance with therapeutic instruction (Schultz, 1980) and may actually impel the client out of treatment (Baekeland & Lundwall, 1975). Attesting to the importance of establishing side bets in the family arena is the extensive family systems literature, replete with methods for challenging clients' commitments to pathological family systems.

CONTRIBUTIONS TO BONDING PROCESSES

Many of the variables related to dropout may affect the bonding process in the commitment model: the process by which the positive and negative elements of therapy, experienced or anticipated at any point in time, are conceptually integrated and the role of the helper–client dyad in achieving a

better future is defined. Client characteristics may be related to bonding difficulties. For example, sociopaths are notoriously difficult to hold in treatment. Their impulsive terminations may be understood as behavioral manifestations of their difficulties in forming conceptual bonds between the requirements of the current situation (following the rules of treatment) and their long-term goals (keeping out of trouble in the future). In addition, the sociopath lacks the anxiety that would enhance susceptibility to whatever conceptual framework the helper has to offer.

Characteristics of the therapist may either enhance or detract from the client's acceptance of the helper's ideas. The fact that more likable and less aloof therapists hold clients better may reflect the greater credibility of communicators who are perceived as attractive and trustworthy (Zimbardo, Ebbesen, & Maslach, 1977). Clients may well be more receptive to interpretations about the inevitable ups and downs of the therapy experience when these are offered by helpers they like and whom they believe to be interested in their care.

The contribution to dropout of discrepant expectations of client and helper may also be understood in terms of bonding processes. For example, clients from lower socioeconomic groups who expect symptom relief and medication have high dropout rates from clinics offering psychoanalytically oriented psychotherapy emphasizing insight and self-exploration of a long-term nature. Unless special attention is given to winning over such clients, it is unlikely that they are going to be convinced that their helpers' perspective is relevant to their concerns in therapy. In a similar vein, the fact that less psychologically minded clients are less likely to persevere in treatment makes sense given the psychological world views promulgated by helpers in the mental health industry.

What constitutes a major concern requiring conceptual bonding for a particular client to persevere in treatment varies from one person to the next. A staunch Protestant who believes that good things come only through suffering and self-denial may have no difficulty with the expense of therapy or an hour's drive to the therapist's office for lengthy insight-oriented therapy. The same individual may bolt if a suggestion is made to bring her family to treatment, since she believes she should not "burden" her husband and children when "the only problem is my nerves." Helper–client matching may forestall dropout by enhancing the likelihood that clients will be offered conceptual frameworks in therapy that they find relevant to their predominant concerns.

Social-Psychological Approaches to Commitment

Having demonstrated the utility of the commitment framework in our consideration of the stages of psychotherapy and the research on psychotherapy dropout, we turn now to the social-psychological literature and review methods for inducing initial commitment and for maintaining commitment to the pursuit of psychotherapy.

INDUCING INITIAL COMMITMENT

All of the methods for inducing commitment that we will discuss aim at eliciting initial behavior on the basis of which subsequent commitment to therapy can be forged. The approaches vary, however, in whether the initial behavior is more or less extreme than the ultimate behaviorial target.[1] We and, in cases where a different behavior is initially sought, in whether this behavior is more or less extreme than the ultimate behavioral target.[1] We believe that the methods we review are especially relevant to the early phases of therapy, when clients first become aware of its emotional and financial costs and the ambivalence of Stage II threatens perseverance in treatment. As our review indicates, the degree to which clients experience an aspect of therapy as positive or negative and the conceptual constellation they use to relate these elements to ongoing behavior are malleable and can readily be influenced by systematic attempts on the part of the therapist.

Focus on the Actual Target Behavior

Festinger's (1957) cognitive dissonance theory formed the basis for much of the early work on inducing commitment. This initial research typically used a "forced compliance" paradigm, first paying subjects varying amounts of money to publicly express an opinion counter to their actual attitudes and then reassessing their attitudes (e.g., Festinger & Carlsmith, 1959; Linder, Cooper, & Jones, 1967). Consistent with dissonance theory predictions, these studies generally found an inverse relationship between the amount of reward and the amount of attitude change in the direction of the publicly expressed opinion: The less money offered, the greater the subsequent attitude change (cf. Gerard *et al.*, 1974). The dissonance explanation rests on the assumption that people experience cognitive dissonance when their behavior is not sufficiently justified (Cohen, 1962; Gerard *et al.*, 1974). If subjects receive $20 for writing counterattitudinal essays, for example, the large extrinsic incentive may provide sufficient justification. If they receive only a few cents for making the same statement, however, the extrinsic incentive is insufficient to justify saying something they do not believe, cognitive dissonance is aroused, and in

[1]We exclude from our discussion methods that initially focus on more extreme versions of the target behavor. Research indicates that people who refuse a larger initial request are more likely to agree to a smaller second request than are people not first presented with the large initial request (Cialdini, Vincent, Lewis, Catalan, Wheeler, & Darby, 1975). Such "door-in-the-face" techniques have limited applicability in clinical settings and raise ethical issues beyond the scope of this chapter.

order to reduce this tension subjects justify their behavior by finding another explanation for it (e.g., that they really *do* believe what they just said).[2]

Closely related to the forced compliance studies is research on the relationship between severity of initiation and attraction. This research has demonstrated that the more effort voluntarily expended in pursuing a freely chosen behavioral course, the stronger one's attraction to that course (Aronson, 1961; Aronson & Mills, 1959; Gerard & Mathewson, 1966).

The key to enhancing commitment through insufficient justification lies in the person's perception of a *high degree of choice* in performing the target behavior, with minimal extrinsic justification (Gerard *et al*., 1974; Wicklund & Brehm, 1976). Whether one takes the dissonance or self-perception perspective, insufficient justification procedures can be viewed as inducing commitment by putting cognitive consistency at stake for the individual, who becomes subsequently committed to a particular course of action through the need to preserve consistency between attitude and behavior. Although the target behavior must have at least a minimal appeal, this paradigm suggests how it may become more attractive as a function of changing costs and rewards incurred in its pursuit. Emphasizing to the client that whether to pursue treatment or not is their free choice, while requiring effort to persist and only the minimal effective external justification for doing so, should increase the client's sense of commitment. And if Kanter (1968) is correct in her contention that sacrifice by the client promotes commitment, then clients' perceptions that they are voluntarily paying a considerable sum of money for therapy should lead them to become more commited to the endeavor.

The low-ball technique (Cialdini *et al*., 1978) is another mechanism for fostering commitment that focuses on inducing commitment to the target behavior right from the start. This procedure involves first offering sufficient extrinsic incentives to induce an individual to make an active decision regarding a given course of behavior, and then removing the extrinsic incentives. Despite the lower rewards, the person will tend to remain committed to the initial decision and will be more likely to continue the decided-upon behavior without the extrinsic rewards than someone presented with only the more costly request. A parallel body of dissonance research indicates that negative consequences of behavior that people foresee only after commitment to a course of action often lead to enhanced efforts to justify the course of action chosen (Cooper, 1971; Goethals & Cooper, 1975; Goethals, Cooper, & Naficy, 1979).

[2]Bem's (1967) self-perception theory provides an alternative explanation for these findings. According to self-perception theory, in the absense of clear situational influences, people make inferences about their attitudes, beliefs, and motives by observing their own behavior. Thus, perceiving onself as having chosen to write a counterattitudinal essay for only a few cents would lead a person to conclude that he or she must actually believe in the newly expressed opinion. Shifting self-perceptions presumably underlie attitude change. Supporting this interpretation, explicitly labeling donors as charitable produces greater rates of subsequent donation than procedures without explicit labeling (Kraut, 1973).

The low-ball approach is frequently used by modern psychoanalysts. Although clients who begin pursuing psychoanalysis with a warm analyst with whom they talk face-to-face may be surprised when their therapist becomes more "depriving" and requests a shift to the couch, they are nevertheless more likely to persevere than clients plunged directly into the classical psychoanalytic relationship without such preparation.

The explanation first offered for this low-ball effect was that the initial commitment to an uncoerced decision persists over time by creating self-perceptions of favorability toward the decision, which increase willingness to comply with higher costs (Cialdini *et al*., 1978). However, a more recent series of experiments (Burger & Petty, 1981) suggests that an unfulfilled obligation to to the requester, rather than a commitment to the target behavior, may be responsible for the success of the low-ball technique. Burger and Petty found that the low-ball strategy was effective only when both the first request and the second, more costly request were made by the same person. Furthermore, subjects were more likely to comply with a second, more costly request when it was made by the same person, even if the second request was unrelated to the initial one. This evidence clearly indicates that commitment to the requester, and not to the behavior initially requested, underlies the low-ball phenomenon.

Focus on a Less Extreme Version of Target Behavior

Several other procedures for inducing commitment operate on the principle that people strive to maintain consistency between self-perceptions and behavior. For instance, many studies have found that people are more likely to comply with a large request if they have previously agreed to a smaller initial request (Pliner, Hart, Kohl; & Saari, 1974; Seligman, Bush; & Kirsch, 1976; Snyder & Cunningham, 1975). In a fund drive for the Cancer Society, for example, asking people to comply with the simple initial request to wear a pin publicizing the campaign nearly doubled the rate of subsequent donation (Pliner *et al*., 1974). One explanation for this "foot-in-the-door" effect is that initial compliance under conditions of low external pressure heightens the self-perception that one is a helpful, compliant person, thus making one more likely to comply with a subsequent larger request (see DeJong, 1979). As with the insufficient justification effect, the amount of external pressure used to induce initial compliance is crucial. If people perceive a sufficient extrinsic justification for having agreed to the initial request, then they will not make self-inferences of compliance and may be less willing to comply with the subsequent request (Zuckerman, Lazzaro, & Waldgeir, 1979).

Many a helper has used the foot-in-the-door approach to induce client commitment without labeling it as such. For example, the first author routinely requests that a client make a decision to come to only three sessions and actually discourages the client from making any longer-term commitment without the experience this trial would provide. This approach has several

virtues. The initial small request is easier to comply with than a request to embark on a lengthy course of therapy. Secondly, the subsequent decision to pursue treatment beyond the initial three visits is based more on the clients' perception of their *own* behavior during the initial sessions than on simple adherence to pressure or persuasion by the helper. Finally, once consistency between self-image and behavior is a side bet for an individual, refusal to continue treatment threatens his or her self-image as a "good patient."

The effectiveness of the procedures discussed for inducing commitment—through focusing on the actual target behavior (insufficient justification, low-ball) or through focusing on a less extreme version of the target behavior (foot-in-the-door)—all depend on the individual's perception of a high degree of personal choice. Perceptions of choice presumably foster self-attributions of responsibility for behavior (Wicklund & Brehm, 1976). This assumption is consistent with recent attributional formulations (e.g., Mayer, Duval, & Duval, 1980) that stress the importance of perceived personal responsibility as an antecedent of commitment. Feeling that one has personally chosen a behavioral course apparently mediates the effectiveness of commitment-inducing procedures (cf. Kiesler, 1971).

MAINTAINING COMMITMENT

In the previous section we reviewed methods for enhancing the initial commitment among clients facing the ambivalence characteristic of the early phase of treatment. We now focus on the role of attributions and expectancies in enhancing persistence beyond these first confrontations with ambivalence. We believe that the attributions and expectancies that clients bring to therapy, and those shaped by the helper in the early stages of treatment, are especially critical for weathering the inevitable recurrence of peaks and valleys at different points in the therapy experience.

Causal and Moral Attributions

A fundamental premise of attribution theory is that persistence is mediated by the perceived causes of behavioral outcomes. A person who attributes failure in an endeavor to insufficient ability, for example, is likely to give up sooner than one who attributes failure to insufficient effort. Studies of achievement behavior (Rest, Nierenberg, Weiner, & Heckhausen, 1973; Weiner, Heckhausen, Meyer, & Cook 1972) confirm that effort attributions underlie achievement motivation and persistence. Procedures that emphasize insufficient effort as a cause of failure have been found to produce greater persistence in the face of failure than procedures that do not (Dweck, 1975; Dweck & Repucci, 1973), consistent with the notion that self-attributions of responsibility enhance commitment (Kiesler, 1971; Mayer *et al.*, 1980).

Brickman, Rabinowitz, Karuza, Coates, Cohn, and Kidder (1982) have recently modified the traditional perspective on causal attribution by distinguishing between attributions of responsibility for the *problem* and attributions of responsibility for the *solution*. Within this framework, they propose that helping relationships be classified according to those that emphasize personal responsibility for: (*a*) both the problem and the solution (called the "moral model"); (*b*) only the problem, but not the solution (the "enlightenment model"); (*c*) only the solution, but not the problem (the "compensatory model"); and (*d*) neither the problem nor the solution (the "medical model"). (See Chapter 6, by Karuza, Zevon, Rabinowitz, & Brickman in this volume.) Clients and helpers are seen as implicitly holding to one of these four models. To enhance persistence in therapy, the helper would do well to assess the type of model held by the client and to tailor the therapeutic approach accordingly. As Fish (1973) noted, "By allowing the success of therapy to hinge on the weakening or destruction of a patient's cherished beliefs, the therapist has greatly diminished the chances of success [p. 95]."

Certain attributions may nevertheless be more conducive to both persistence and symptom relief than others. For example, teaching clients to attribute improvement to personal effort produces greater benefits (Chambliss & Murray, 1979; Davison & Valins, 1969; Liberman, 1978), whereas stressing external responsibility for improvement yields, at best, only temporary gains (Jeffrey, 1974; Miller, Brickman, & Bolen, 1975; Nentwig, 1978). Positive attributional sets apparently facilitate commitment by providing clients with a useful means of conceptually bonding positive elements (such as the anticipation of relief) with negative elements (such as the experience of pain) so as to provide a rationale for persistent involvement.

Brickman *et al.* (1982) conclude from their review of the literature that attributions of responsibility for *solutions* mediate persistence and improvement, a hypothesis we are currently pursuing in a therapy analogue laboratory study (Bryant, Lemkau, & Brickman, Note 2).

An example from the practice of one of the authors (JPL) illustrates the role of attributions for solutions at a critical point in treatment. An extremely depressed middle-aged man repeatedly and belligerently asked his therapist, "Have you got your magic wand yet?" In response to her consistent refusal (and inability!) to produce a magic solution, the man finally said in exasperation, "I guess you can fall into a ditch but you can't fall out!" From that point on, he energetically pursued his *own* solutions, using the therapist as a consultant to his efforts, only occasionally baiting her with entreaties to "turn the ditch over and let me out!" Such attributional transitions in therapy may be risky times for dropout if the client's expectations of the therapist are dashed before a new type of relationship is perceived as possible and desirable.

One specific method for changing clients' attributional styles so as to facilitate persistence and therapeutic benefit is that of "reattribution training" (Abramson, Seligman, & Teasdale, 1978; Dweck, 1975; Ross, Rodin, &

Zimbardo, 1969; Valins & Nisbett, 1971). This approach involves teaching people to make more adaptive attributions for environmental and behavioral outcomes. For example, training children with learning difficulties to attribute their failures to insufficient effort produced greater subsequent persistence and performance improvement in the face of failure than did only giving them experience with success (Dweck, 1975). Clinicians have reported positive results using similar, cognitive restructuring procedures in the treatment of depression (Beck, 1976, Shaw, 1977), neurosis (Ellis, 1962), and paranoia (Davison, 1966).[3]

Expectations

Another determinant of persistence is the individual's expectation of success. Whereas high expectations of the results of therapy may contribute to the client's return for a second or third visit, positive expectations alone may be insufficient to maintain long-term commitment, and may actually undermine persistence by leaving the client unprepared for the inevitable slumps in the therapeutic course. Positive expectations need to be tempered by realistic anticipation that "one step backward" often comes with the "two steps forward."

Our perspective is consistent with issues raised in the research literature. In general, people with high expectations persist longer and perform better than people with low expectations. People with high expectations of success not only work harder and persist longer, but also do better following failure than people with low expectations of success (Brickman & Hendricks, 1975; Means & Means, 1971; Miller *et al.* 1975; Shrauger & Sorman, 1977). Conversely, people who expect to fail often show performance decrements even before receiving explicit feedback (Hiroto & Seligman, 1975; Roth & Kubal, 1975).

Wortman, and Brehm (1975) contend that persistence in the face of failure is a direct function of expectation of control: The higher the initial expectation, the greater the resultant motivation to persist to exert control. Unrealistically high expectancies, however, when dashed, can lead to dissatisfaction, demoralization, and dropout. As Wortman and Brehm suggest, the magnitude helplessness experienced when quitting in the face of failure is also a direct function of expectation of control: The higher the initial expectation, the greater the subsequent helplessness effects. Paralleling Wortman and Brehm's model, a recent review of research on performance expectations (Linsenmeier &

[3]Although attributions that enhance persistence are adaptive in objectively controllable situations where the client's efforts will ultimately be rewarded, they are maladaptive in objectively uncontrollable situations (cf. Janoff-Bulman & Brickman, 1981; Wortman & Brehm, 1975). For example, the woman who accepts her therapist's suggestion that only by choosing to be sexually involved with him will she find solutions to her problems, may persist in therapy and even pay for such "help." Several authors have suggested "immunization training" in which people are taught to differentiate between controllable and uncontrollable outcomes (cf. Janoff-Bulman & Brickman, 1982; Wortman & Brehm, 1975).

Brickman, Note 3) suggests that expectations of success have both positive and negative consequences. Paradoxically, higher expectations produce better performance but also generate lower satisfaction with outcomes; lower expectations produce poorer performance but also generate greater satisfaction with outcomes.

In considering the implications of this literature for the psychotherapeutic dyad, it is critical to distinquish between expectations for achieving the ultimate goals of therapy and expectations for the more immediate course. By raising expectations about ultimate success (e.g., stressing that the client will undoubtedly improve by the end of therapy) while simultaneously reducing expectations about the course of the therapeutic course (e.g., stressing that improvement may very well involve some necessary setbacks), the therapist can capture the benefits of both high and low expectancies as well as counteract their disadvantages. As Fish (1973) writes,

> a therapist can mention that because of the nature of psychological problems, on rare occasions a patient may regress if he has reached a point where such regression enables him to learn to cope with his problems. If the patient gets worse, the therapist can sympathize with him over how painful progress can be, while suggesting that once he has benefited from his therapeutic regression, he will be able to make still greater and less painful strides [p. 37].

We would expect this paradoxical approach to increase commitment to the helping relationship, for when clients hold expectations of both ultimate relief and suffering and setbacks in the process, they have a cognitive map to facilitate the continuous integration of positive and negative elements experienced along the way.

Conclusion

Commitment is at the heart of the psychotherapeutic enterprise. As clients readily attest, therapy is *work*, often involving arduous assignments, painful emotions, and considerable expense. Given the inevitable costs faced by psychotherapy clients, and the fact that helpers rarely choose to treat their clients with only one or two sessions, the development and maintenance of commitment is crucial for helper and client alike.

We began by defining commitment in terms of a person's choice of a behavioral direction and his or her persistence on that course in the face of ambivalence. By reframing psychoanalytic descriptions of stages of therapy, we demonstrated the relevance of commitment processes to the therapeutic dyad, whatever the particular helper's philosophy of treatment. Factors predictive of psychotherapy dropout were also discussed with reference to positive and negative elements in therapy and the integration of these within

the commitment framework. We suggested that by attending to commitment processes, helpers enhance the likelihood that their clients will remain in treatment and weather the inevitable fluctuations in the therapeutic course, and we illustrated the applicability of paradigms for inducing and maintaining commitment, drawn from the literature of social psychology applied to the psychotherapy setting. From the literature on causal and moral attributions we were reminded of the importance of fostering clients' beliefs that their own efforts in therapy will result in the personal changes they desire and of attending to the world view of the client in considering any interventions. Finally, the literature on expectations underlined the role of the helper in maintaining high client aspirations for ultimate success while tempering expectations for the more immediate future. We conclude by suggesting that helpers need to design interventions to help clients integrate their stage in therapy with expectations of ultimate benefit.

We think that commitment processes are the very essence of psychotherapy. Although this is a sweeping assertion, we find nothing in the clinical or social-psychological literature that compels us to think otherwise. Moreover, we are confident that even those who believe that fostering client commitment is only a means to hold clients in therapy long enough so that change may be effected through other avenues will agree that commitment processes should be high on our clinical and research agendas.

Reference Notes

1. Brickman, P. *Commitment*. Unpublished manuscript, University of Michigan, 1981.
2. Bryant, F., Lemkau, J. P., & Brickman, P. *Effects of expectancies and causal attributions for problem and solution on persistence at a therapy analogue task*. Work in progress, University of Michigan, 1981.
3. Linsenmeier, J., & Brickman, P. *Expectations, performance and satisfaction*. Unpublished manuscript, University of Michigan, 1981.

References

Abramson, L. Y., Seligman, M. E. P., & Teasdale, J. D. Learned helplessness in humans: Critique and reformulation. *Journal of Abnormal Psychology*, 1978, *87*, 49–74.

Aronson, E. The effect of effort on the attractiveness of rewarded and unrewarded stimuli. *Journal of Applied Social Psychology*, 1961, *63*, 375–380.

Aronson, E., & Mills, J. The effect of severity of initiation on liking for a group. *Journal of Applied Social Psychology*, 1959, *59*, 177–181.

Baekeland, F., & Lundwall, L. Dropping out of treatment: A critical review. *Psychological Bulletin*, 1975, *82*, 738–783.

Beck, A. T. *Cognitive therapy and emotional disorders*. New York: International Universities Press, 1976.

Becker, H. S. Notes on the concept of commitment. *American Journal of Sociology*, 1960, *66*, 32–40.

Bem, D. J. Self perception: An alternative interpretation of cognitive dissonance phenomena. *Psychological Review*. 1967, *74*, 183–200.

Bergin, A. E., & Lambert, M. J. The evaluation of therapeutic outcomes. In S. L. Garfield & A. E. Bergin (Eds.), *Handbook of psychotherapy and behavior change: An empirical analysis* (2nd ed.). New York: Wiley, 1978.

Brickman, P., & Hendricks, M. Expectancy for gradual or sudden improvement and reaction to success and failure. *Journal of Personality and Social Psychology*, 1975, *32*, 893–900.

Brickman, P., Rabinowitz, V. C., Karuza, J., Jr., Coates, D., Cohn, E., & Kidder, L. Models of helping and coping. *American Psychologist*, 1982, *37*, 368–384.

Burger, J. M., & Petty, R. E. The low-ball compliance technique: Task or person commitment? *Journal of Personality and Social Psychology*, 1981, *40*, 497–499.

Chambliss, C. A., & Murray, E. J. Efficacy attribution, locus of control, and weight loss. *Cognitive Therapy and Research*, 1979, *3*, 349–353.

Cialdini, R. B., Cacioppo, J. T., Bassett, R., & Miller, J. A. Low-ball procedure for producing compliance: Commitment then cost. *Journal of Personality and Social Psychology*, 1978, *36*, 463–476.

Cialdini, R. B., Vincent, J. E., Lewis, S. K., Catalan, J., Wheeler, D., & Darby, B. L., Reciprocal concessions procedure for inducing compliance: The door-in-the-face technique. *Journal of Personality and Social Psychology*, 1975, *31*, 206–215.

Cohen, A. R. An experiment on small rewards for discrepant compliance and attitude change. In J. W. Brehm & A. R. Cohen (Eds.), *Explorations in cognitive dissonance*. New York: Wiley, 1962.

Cooper, J. Personal responsibility and dissonance: The role of foreseen consequences. *Journal of Personality and Social Psychology*, 1971, *18*, 354–363.

Davison, G. Differential relaxation and cognitive restructuring in therapy with a "paranoid schizophrenic" or "paranoid state." *Proceedings of the American Psychological Association 74th Annual Convention* 1966, 177–178.

Davison, G. C., & Valins, S. Maintenance of self-attributed and drug-attributed behavior change. *Journal of Personality and Social Psychology*, 1969, *11*, 25–33.

DeJong, W. An examination of self-perception mediation of the foot-in-the-door effect. *Journal of Personality and Social Psychology*, 1979, *37*, 2221–2239.

Dweck, C. S. The role of expectations and attributions in the alleviation of learned helplessness. *Journal of Personality and Social Psychology*, 1975, *31*, 674–685.

Dweck, C. S., & Repucci, N. D. Learned helplessness and reinforcement responsibility in children. *Journal of Personality and Social Psychology*, 1973, *25*, 109–116.

Eidelson, R. J. Interpersonal satisfaction and level of involvement: A curvilinear relationship. *Journal of Personality and Social Psychology*, 1980, *39*, 460–470.

Ellis, A. *Reason and emotion in psychotherapy*. New York: Lyle Stuart, 1962.

Festinger, L. *A theory of cognitive dissonance*. Stanford: Stanford Univ. Press, 1957.

Festinger, L., & Carlsmith, J. M. Cognitive consequences of forced compliance. *Journal of Abnormal and Social Psychology*, 1959, *58*, 203–210.

Fine, R. Psychoanalysis. In R. Corsini (Ed.), *Current psychotherapies*. Itasca, Ill.: Peacock, 1973.

Fish, J. M. *Placebo therapy*. San Francisco: Jossey-Bass, 1973.

Frank, J. D. Immediate and long-term symptomatic course of psychiatric outpatients. *American Journal of Psychiatry*, 1963, *120*, 429–439.

Frank, J. D. *Persuasion and healing* (Rev. ed.). New York: Schocken, 1974.

Gerard, H. B. Conolley, E. S., & Wilhelmy, R. A. Compliance, justification, and cognitive change. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 7). New York: Academic Press, 1974.

Gerard, H. B., & Mathewson, G. D. The effects of severity of initiation on liking for a group: A replication. *Journal of Experimental Social Psychology*, 1966, *2*, 278–287.

Goethals, G. R., & Cooper, J. When dissonance is reduced: The timing of self-justificatory attitude change. *Journal of Personality and Social Psychology*, 1975, *32*, 361–367.

Goethals, G. R., Cooper, J., & Naficy, A. Role of foreseen, foreseeable, and unforeseeable behavioral consequences in the arousal of cognitive dissonance. *Journal of Personality and Social Psychology*, 1979, *37*, 1179–1185.

Greenson, R. R. *The technique and practice of psychoanalysis* (Vol. 1). New York: International Universities Press, 1967.

Hiroto, D. S., & Seligman, M. E. P. Generality of learned helplessness in man. *Journal of Personality and Social Psychology*, 1975, *31*, 311–327.

Janoff-Bulman, R., & Brickman, P. Expectations and what people learn from failure. In N. T. Feather (Ed.), *Expectations and actions*. Hillsdale, N. J.: Erlbaum, 1982.

Jeffrey, D. B. A comparison of the effects of external control and self-control on the modification and maintenance of weight. *Journal of Abnormal Psychology*, 1974, *83*, 404–410.

Kanter, R. M. Commitment and social organization: A study of commitment mechanisms in Utopian communities. *American Sociological Review*, 1968, *33*, 499–517.

Kiesler, C. A. *The psychology of commitment*. New York: Academic Press, 1971.

Kraut, R. E. Effects of social labeling on giving to charity. *Journal of Experimental Social Psychology*, 1973, *9*, 551–562.

Liberman, B. L. The role of mastery in psychotherapy: Maintenance of improvement and prescriptive change. In J. D. Frank, R. Hoehn-Saric, D. D. Imber, B. L. Liberman, & A. R. Stone, *Effective ingredients of successful psychotherapy*. New York: Brunner/Mazel, 1978.

Linder, D. E., Cooper, J., & Jones, E. E. Decision freedom as a determinant of the role of incentive magnitude in attitude change. *Journal of Personality and Social Psychology*, 1967, *6*, 245–254.

Mayer, F. S. Duval, S., & Duval, V. H. An attributional analysis of commitment. *Journal of Personality and Social Psychology*, 1980, *39*, 1072–1080.

Means, R. S., & Means, G. H. Achievement as a function of the presence of prior information concerning aptitude. *Journal of Educational Psychology*, 1971, *62*, 185–187.

Miller, R. T., Brickman, P., & Bolen, D. Attribution versus persuasion as a means of modifying behavior, *Journal of Personality and Social Psychology*, 1975, *31*, 430–441.

Nentwig, C. G. Attribution of cause and long-term effects of the modification of smoking behavior. *Behavioral Analysis and Modification*, 1978, *2*, 285–295.

Pliner, P., Hart, H., Kohl, J., & Saari, D. Compliance without pressure: Some further data on the foot-in-the-door technique. *Journal of Experimental Social Psychology*, 1974, *10*, 17–22.

Rest, S., Nierenberg, R., Weiner, B., & Heckhausen, H. Further evidence concerning the effects of perceptions of effort and ability on achievement evaluation. *Journal of Personality and Social Psychology*, 1973, *28*, 187–191.

Rosenthal, D., & Frank, J. D. The fate of psychiatric clinic outpatients assigned to psychotherapy. *Journal of Nervous and Mental Disease*, 1958, *127*, 330–343.

Ross, L. The intuitive psychologist and his shortcomings. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 10). New York: Academic Press, 1977.

Ross, L. D., Rodin, J., & Zimbardo, P. G. Toward an attribution therapy: The reduction of fear through reduced cognitive–emotional misattribution. *Journal of Personality and Social Psychology*, 1969, *12*, 279–288.

Roth, S., & Kubal, L. The effects of noncontingent reinforcement on tasks of differing importance: Facilitation and learned helplessness. *Journal of Personality and Social Psychology*, 1975, *32*, 680–691.

Schultz, S. K. Compliance with therapeutic regimes in pediatrics. *Social Work in Health Care*, 1980, *5*, 267–278.

Seligman, C., Bush, M., & Kirsch, K. Relationship between compliance in the foot-in-the-door paradigm and size of first request. *Journal of Personality and Social Psychology*, 1976, *33*, 517–520.

Shaw, B. F. Comparison of cognitive therapy and behavior therapy in the treatment of depression. *Journal of Consulting and Clinical Psychology*, 1977, *45*, 543–551.

Shrauger, J. S., & Sorman, P. B. Self-evaluations, initial success and failure, and improvement as determinants of persistence. *Journal of Consulting and Clinical Psychology*, 1977, *45*, 784–795.

Smith, M. L., & Glass, G. V. Meta-analysis of psychotherapy outcome studies. *American Psychologist*, 1977, *32*, 752–760.

Snyder, M., & Cunningham, M. R. To comply or not to comply: Testing the self-perception explanation of the "foot-in-the-door" technique. *Journal of Personality and Social Psychology*, 1975, *31*, 64–67.

Torrey, E. F. *The mind game: Witch doctors and psychiatrists*. New York: Emerson Hall, 1972.

Uhlenhuth, E. H., & Duncan, D. B. Subjective change with medical student therapists: II. Some determinants of change in psychoneurotic outpatients. *Archives of General Psychiatry*, 1968, *18*, 532–540.

Valins, S., & Nisbett, R. E. *Attribution processes in the development and treatment of emotional disorders*. Morristown, N.J.: General Learning Press, 1971.

Weiner, B., Heckhausen, H., Meyer, M., & Cook, R. E. Causal ascriptions and achievement behavior: Conceptual analysis of effort and reanalysis of locus of control. *Journal of Personality and Social Psychology*, 1972, *21*, 239–248.

Wicklund, R. A., & Brehm, J. W. *Perspectives on cognitive dissonance*. New York: Wiley, 1976.

Wortman, C. B., & Brehm, J. W. Responses to uncontrollable outcomes: An integration of reactance theory and the learned helplessness model. In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 8). New York: Academic Press, 1975.

Zimbardo, P. G., Ebbesen, E. B., & Maslach, C. *Influencing attitudes and changing behavior* (2nd ed.). Reading, Mass.: Addison-Wesley, 1977.

Zuckerman, M., Lazzaro, M. M., & Waldgeir, D. Undermining effect of the foot-in-the-door technique with extrinsic rewards. *Journal of Applied Social Psychology*, 1979, *9*, 292–296.